Workers' Safety & Compensation Division

Cheyenne Business Center 1510 E. Pershing Blvd.
Cheyenne, Wyoming 82002
(307) 777-7441

Agreement for Temporary Light Duty / Restricted Work

Employer Name

Street Address

City, State, Zip

Employee Workers' Compensation Case Number

Employee Name

Street Address

City, State, Zip

Terms of Light Duty / Restricted Work

On this date, _____, the employer named above, makes the following offer of light duty work to the employee named above. The number of days per week will be _____, and the number of hours per day will be _____. The wage for this position will be $_____per_____. This position begins ____/____/____ Expected duration of this position is _____ days.

The duties of this position are: _____

_____

_____

_____

The maximum physical requirements of this position are listed below:

_____

_____

_____

_____

EMPLOYER CERTIFICATION

I certify I am the employer or authorized to represent the employer offering light / restricted duty to employee in good faith and in accordance with Wyoming Statute [The Act] § 27-14-404(j).

_____ _____ _____

Name Phone Number Date

Physical limitations provided by the employee's doctor are listed below:

_____

_____

The anticipated date of return to unrestricted work for this employee is _____/_____/_____. This is subject to change with proper medical documentation and justification. The offer will not extend beyond the requirements of Wyoming Statute § 27-14-404 (b).

HEALTH CARE PROVIDER CERTIFICATION

I certify I have examined this employee and agree the physical and mental requirements and restrictions of this light duty position are within the employee's limitations. I hereby authorize employee to return to work subject to the light duty restrictions stated in this agreement.

_____
Printed Health Care Provider Name

_____ _____ _____
Health Care Provider Signature Date

EMPLOYEE CERTIFICATION

I certify I will follow the doctor's medical restrictions. I agree to immediately notify the Division of Worker's Safety and Compensation and my employer of any change in my restrictions with a written note from my health care provider. I agree to notify the Division and my health care provider(s) immediately if I return to full time employment. I also agree to contact my claims analyst if any problems arise regarding the temporary light duty assignment. I understand Temporary Partial Disability benefits will be paid monthly.

☐ I accept employer's offer for light duty work.

☐ I refuse employer's offer for light duty work.

_____
Print Employee Name

_____ _____ _____
Employee Signature Date

Reason for refusal (optional):_____

_____